



OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

Appendix C to Sec. 1910.134:



Part A. Section 1. (Mandatory) Every employee who has been selected to use any type of respirator (please print) must provide the following information.

Today's date _____
 Name _____
 Job Title _____
 Home Phone: _____
 Work Phone: _____

Date of Birth: _____
 SSN: _____
 Sex: Male ☐ Female ☐
 Height: _____ (ft) _____ (in) Weight _____ (lbs)

Can you read English? Yes ☐ NO ☐

Has your employer told you how to contact the health care professional who will review this? Yes ☐ NO ☐

Check the type of respirator you will use (you can check more than one category):

a _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).	
b _____ Other type	<input type="checkbox"/> Powered-air purifier
<input type="checkbox"/> Half-face	<input type="checkbox"/> Supplied-air
<input type="checkbox"/> Full-facepiece type (includes gas mask)	<input type="checkbox"/> Self-contained breathing apparatus

Have you worn a respirator in the past?: Yes ☐ NO ☐

If "yes," what type(s): _____

Physical exertion while wearing a respirator ☐ Mild ☐ Moderate ☐ Strenuous

Maximum time you wear a respirator in a single day?: _____ hours

Do you exercise? Yes ☐ NO ☐

If "yes," describe how often and what exercise activities are: _____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please select "yes" or "no").

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes ☐ NO ☐

If Yes, how many packs per day? ☐ 1/2 or less ☐ 1 ☐ 2 ☐ 2 or more

How many years have you smoked? ☐ 1-9 ☐ 10-19 ☐ 20-29 ☐ 30 or more

2. Have you ever had any of the following conditions?

Seizures (fits)	Yes <input type="radio"/> NO <input type="radio"/>
Diabetes (sugar disease)	Yes <input type="radio"/> NO <input type="radio"/>
Allergic reactions that interfere with your breathing	Yes <input type="radio"/> NO <input type="radio"/>
Claustrophobia (fear of closed-in places)	Yes <input type="radio"/> NO <input type="radio"/>
Trouble smelling odors	Yes <input type="radio"/> NO <input type="radio"/>

3. Have you ever had any of the following pulmonary or lung problems?

Asbestosis	Yes <input type="radio"/> NO <input type="radio"/>
Asthma	Yes <input type="radio"/> NO <input type="radio"/>
Chronic bronchitis:	Yes <input type="radio"/> NO <input type="radio"/>
Emphysema:	Yes <input type="radio"/> NO <input type="radio"/>
Pneumonia	Yes <input type="radio"/> NO <input type="radio"/>
Tuberculosis	Yes <input type="radio"/> NO <input type="radio"/>
Silicosis	Yes <input type="radio"/> NO <input type="radio"/>
Pneumothorax (collapsed lung)	Yes <input type="radio"/> NO <input type="radio"/>
Lung cancer	Yes <input type="radio"/> NO <input type="radio"/>
Broken ribs:	Yes <input type="radio"/> NO <input type="radio"/>
Any chest injuries or surgeries:	Yes <input type="radio"/> NO <input type="radio"/>
Any other lung problem that you've been told about:	Yes <input type="radio"/> NO <input type="radio"/>

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

- | | | |
|---|---------------------------|--------------------------|
| Shortness of breath: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Shortness of breath when walking fast on level ground or walking up a slight hill/incline | Yes <input type="radio"/> | NO <input type="radio"/> |
| Shortness of breath when walking with other people at an ordinary pace on level ground: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Have to stop for breath when walking at your own pace on level ground: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Shortness of breath when washing or dressing yourself: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Shortness of breath that interferes with your job: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Coughing that produces phlegm (thick sputum): | Yes <input type="radio"/> | NO <input type="radio"/> |
| Coughing that wakes you early in the morning: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Coughing that occurs mostly when you are lying down: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Coughing up blood in the last month: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Wheezing: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Wheezing that interferes with your job: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Chest pain when you breathe deeply: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Any other symptoms that you think may be related to lung | Yes <input type="radio"/> | NO <input type="radio"/> |

5. Have you ever had any of the following cardiovascular or heart problems?

- | | | |
|--|---------------------------|--------------------------|
| Heart attack | Yes <input type="radio"/> | NO <input type="radio"/> |
| Stroke: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Angina: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Heart Failure: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Swelling in your legs or feet (not caused by walking): | Yes <input type="radio"/> | NO <input type="radio"/> |
| Heart arrhythmia (heart beating irregularly): | Yes <input type="radio"/> | NO <input type="radio"/> |
| High blood pressure: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Any other heart problem that you've been told about: | Yes <input type="radio"/> | NO <input type="radio"/> |

6. Have you ever had any of the following cardiovascular or heart symptoms?

- | | | |
|--|---------------------------|--------------------------|
| Frequent pain or tightness in your chest : | Yes <input type="radio"/> | NO <input type="radio"/> |
| Pain or tightness in your chest during physical activity | Yes <input type="radio"/> | NO <input type="radio"/> |
| Pain or tightness in your chest that interferes with your job | Yes <input type="radio"/> | NO <input type="radio"/> |
| In the past two years, have you noticed your heart skipping or missing a beat : | Yes <input type="radio"/> | NO <input type="radio"/> |
| Heartburn or symptoms that is not related to eating | Yes <input type="radio"/> | NO <input type="radio"/> |
| Any other symptoms that you think may be related to heart or circulation problems: | Yes <input type="radio"/> | NO <input type="radio"/> |

7. Do you currently take medication for any of the following problems?

- | | | |
|-----------------------------|---------------------------|--------------------------|
| Breathing or lung problems: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Heart trouble: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Blood Pressure: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Seizures(fits)::: | Yes <input type="radio"/> | NO <input type="radio"/> |

**8. If you've used a respirator, have you ever had any of the following problems?
(If you've never used a respirator, check the following space and go to question 9)**

- | | | |
|--|---------------------------|--------------------------|
| Eye irritation: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Skin allergies or rashes: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Anxiety: | Yes <input type="radio"/> | NO <input type="radio"/> |
| General weakness or fatigue: | Yes <input type="radio"/> | NO <input type="radio"/> |
| Any other problem that interferes with your use of a respirator: | Yes <input type="radio"/> | NO <input type="radio"/> |

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire:

Yes ☐ NO ☐

Name _____

SUPPLEMENTAL: If you are required to use a full-face peice respirator or a Self-Contained Breathing Aparatus (SCBA), complete the following: (If you do not, please sign below.)

10. Have you ever lost vision in either eye (temporarily or permanently): Yes ☐ NO ☐

11. Do you currently have any of the following vision problems?

Wear glasses: Yes ☐ NO ☐

Wear contact lenses: Yes ☐ NO ☐

Color blind: Yes ☐ NO ☐

Any other eye or vision problem: Yes ☐ NO ☐

12. Have you ever had an injury to your ears, including a broken ear drum: Yes ☐ NO ☐

13. Do you currently have any of the following hearing problems?

Difficulty hearing: Yes ☐ NO ☐

Wear a hearing aid: Yes ☐ NO ☐

Any other hearing or ear problem: Yes ☐ NO ☐

14. Have you ever had a back injury: Yes ☐ NO ☐

15. Do you currently have any of the following musculoskeletal problems?

Weakness in any of your arms, hands, legs, or feet: Yes ☐ NO ☐

Back pain: Yes ☐ NO ☐

Difficulty fully moving your arms and legs: Yes ☐ NO ☐

Pain or stiffness when you lean forward or backward at the waist: Yes ☐ NO ☐

Difficulty fully moving your head up or down: Yes ☐ NO ☐

Difficulty fully moving your head side to side: Yes ☐ NO ☐

Difficulty bending at your knees: Yes ☐ NO ☐

Difficulty squatting to the ground: Yes ☐ NO ☐

Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes ☐ NO ☐

Any other muscle or skeletal problem that interferes with using a respirator: Yes ☐ NO ☐

Any additional comments you would like to make:

To the best of my knowledge, the information I have provided is true and accurate.

Employee Signature _____ **Date** _____

TO BE COMPLETED BY THE EXAMINER/REVIEWER:

This employee has been found to be physically able to use the following (check each [] that applies):

- ☐ Single use, filter mask (four attachment points)
- ☐ Half-faced cartridge-type, negative pressure
- ☐ Full-faced cartridge-type respirator, negative pressure
- ☐ Half-faced powered cartridge-type (PAPR)

- ☐ Full-faced powered cartridge-type (PAPR)
- ☐ Self-contained breathing apparatus (SCBA)
- ☐ Hood/helmet powered cartridge-type (PAPR)
- ☐ Half-faced/Full-faced/Hood/Helmet (NOT positive pressure)

Restrictions / Limitations (if any) when wearing a respirator:

- ☐ ***This employee has been found to be physically NOT able to use a respirator***
- ☐ ***There is insufficient information to make a determination at this time***
- ☐ ***The mandatory questionnaire has been reviewed, and the employee has been found to be physically able to use a respirator.***
- ☐ ***The mandatory questionnaire has been reviewed but there is insufficient information to make a determination at this time.***

This respirator clearance expires 1 ☐ 2 ☐ 3 ☐ years from the date below. (If not marked, clearance expires in 1 year)

Reviewer's Name (Print) _____ **Reviewer's Signature** _____ **Date:** _____